

2 PART SURGICAL PATHOLOGY CONSULT REQUISITION

MRN:

PT. NAME:

BIRTHDATE:

GENDER:

CLINIC:

VISIT #:

PATHOL

Pathologist:	SP #:
Date of Receipt:	
Operating Room #	Date of Operation/Service:

COMPLETE ALL ITEMS - PRINT LEGIBLY

Ordering Provider _____ UCSF Provider # _____ Phone/Pager: _____
(Required)

Provider is a(n): Attending Resident/Fellow (attending information required) Allied Health Practitioner (Including attending information if required)

Attending Physician _____ UCSF Provider # _____ Phone/Pager: _____
(Print Name) (Required)

Copy to (Print Name): _____ UCSF Provider # _____ Phone/Pager: _____

Address: _____

Responsible Billing Party Name and Address (if other than patient)

Name: _____ Address: _____

MEDICAL NECESSITY and ICD-9 CODES - REQUIRED

ICD-9 code(s) is/are necessary to indicate medical necessity and for billing purposes. If a carrier might not pay for a test, inform the patient and have them sign Advanced Beneficiary Notice (ABN) to be attached to requisition, indicating responsibility to pay in case of carrier denial of payment.

ICD-9 Code	CLINICAL HISTORY AND PRESENTATION

ORDERING PROVIDER

Consult Slides/Blocks: List materials provided

Tissues Removed:	Note: FROZEN SECTION / FRESH / PERMANENT DOCUMENT TIME IN FORMALIN FOR ALL POTENTIAL ER/PR AND HER2 TESTS.	Total # Specimens
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- 10.
- 11.
- 12.

Special Instructions / Comments:

SP#